PRINTED: 08/29/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF AND PLAN OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	1	MULTIPLE CONSTRUCTION JILDING ING	COMPLETED C 06/14/2017
	OVIDER OR SUPPLIER	(ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP COD 5651 LIMESTONE ROAD WILMINGTON, DE 19808	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFIGIENCY)	ULD BE COMPLETE
F000	INITIAL COMME	NTS	F000		
	was conducted a through June 14, first day of the su sample totaled si sub-sampled resi observation. Abbreviations/de as follows: NHA-Nursing Hold DON-Director of QAC-Quality Ass MD-Medical Door NP-Nurse Practit RN-Registered NPA-Physician Ass LPN-Licensed Pr CNA-Certified Nu UM-Unit Manage MAR-Medication Alzheimer's Diseattacks the brain's memory, thinking Cognitive-thinking Severe Cognitive own decisions; Vital Signs (VS)-c specifically pulse rate, and blood prof a patient's esse Blood Pressure (I the circulatory sydiagnosis since it	urance Coordinator; tor; tor; ioner; urse; sistant; actical Nurse; urse's Aide; r; Administration Record; ase-degenerative disorder that is nerve cells resulting in loss of and language; g, memory, reasoning; Impairment - unable to make celinical measurements, rate, temperature, respiration ressure, that indicate the state ential body functions. BP)-the pressure of the blood in stem, often measured for its closely related to the force eartbeat and the diameter and			
	Pulse (P)-a rhythi	mical throbbing of the arteries			
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE Flactronically Signed	(X6) DATE 07/09/2017

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post aurvey information found on the CMS 2567L.

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	A. BI	MULTIPLE CONSTRUCTION UILDING	COMPLET COMPLET COMPLET	ED
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CC 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DE	
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F000	felt in the wrists of Apical pulse- is to sitting. A stethosh heart and placed (between ribs on Respiratory rate number of breath minute. The normat rest is 12 to 20 respiration rate unique while rest Temperature (T)-person's body. The temperature is an 98.6 F; Fahrenheit (F)-a Fracture-broken S/S-signs and sy Evencare-brand Evencare glucondetermining the aglucose in the block Glucose-the simple source of energy x-ray-type of imalinside of your both ER-emergency of ROM-the full mon Tylenol-brand namedication to tre Tramadol-medication to tre Tramadol-medi	elled through them, typically as or neck; aken when the patient is lying or cope is used to listen to the at the 5th intercostal space. Ieft side of body); (RR or R)-respiratory rate is the as an individuals takes per nal respiration rate for an adult becaths per minute. A under 12 or over 25 breaths per sing is considered abnormal; the degree of internal heat of a che average normal body in oral temperature (by mouth) of temperature scale; bone; mptoms; mame; meter-a medical device for approximate concentration of cod; cle sugar that is the chief for the body; ging that creates pictures of the dy; com; wement potential of a joint; and for acetaminophen, a at pain or reduce fever; ation to treat moderate to chas Set (standardized in clinical documentation of care vided to the resident by the aff;	F000			

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STATEMENT O	F DEFICIENCIES CORRECTION					
9		085033		WING	06/14/	2017
,	OVIOER OR SUPPLIER	ICES - PIKE CREEK	1	STREET ADDRESS, CITY, STATE, ZIP CO 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETE DATE
F157 F157 SS=D	(INJURY/DECLIN (g)(14) Notification (i) A facility must resident; consult and notify, consist the resident representation in results in injury at requiring physicial (B) A significant of physical, mental, a deterioration in status in either life clinical complication (C) A need to alter a need to discontreatment due to a commence a new (D) A decision to resident from the 483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this set that all pertinent in 483.15(c)(2) is a vice a new (D) and the resident in 48 as specified in 48	TIFY OF CHANGES IE/ROOM, ETC) In of Changes. Immediately Inform the with the residents physician; itent with his or her authority, esentative(s) when there issured in the resident which had has the potential for an intervention; in intervention; in the residents or psychosocial status (that is, health, mental, or psychosocial e-threatening conditions or ons); In treatment significantly (that portione an existing form of adverse consequences, or to a form of treatment); or transfer or discharge the facility as specified in anotification under paragraph ection, the facility must ensure information specified in allable and provided upon visician. Instalso promptly notify the esident representative, if any, some or roommate assignment	F167	+:	ent; consult and notify, nority, the en there is- resident at the potential antion; eresidents let	7/7/17 12:

Event ID: YOAZ11

STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A. B	MULTIPLE CONSTRUCTION UILDING //NG	(X3) DATE SURV COMPLETE	D
		085033	1		06/14/2	2017
,	OVIDER OR SUPPLIER	ICES PIKE CREEK		STREET ADDRESS, CITY, STATE, 2 5651 LIMESTONE ROAD WILMINGTON, DE 19808	ZIP CODE	ik:
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F157	Continued From (B) A change in right of the state law or regular paragraph (e)(10) (iv) The facility mupdate the address phone number of the state of the mobility and the fattending physicial the state of the mobility and the fattending physicial the state of the state of the mobility and the fattending physicial the state of	esident rights under Federal or lations as specified in) of this section. ust record and periodically ss (mailing and email) and the resident representative(s). ENT is not met as evidenced record review, staff interviews, er facility documentation, it was he facility falled to consult with resident, for one (R2) out of six ample. R2 had a new onset of left thigh and a change in facility falled to consult the facility falled to consult with facility falled to consult wit	F157	(B) A change in resident Federal or State law or respecified in paragraph (esection. (iv) The facility must recoperiodically update the aland email) and phone nuresident representative(state). 1. The R2 no longer resident nurse that when a resident nurse that when a resident has acute pain and or change the attending physician in of nursing documentative validate the proper evaluation the physican. 3. The Staff Developement and or designee will inseed ucate the Nursing state Consulting a physician wonset of acute pain and mobility. Also if you are not able to comprehensive assessment that has a new onset of change in mobility consulting the resident and evaluating the resident.	rights under egulations as o)(10) of this ord and ddress (mailing amber of the s). des in the facility. g and or designee a new onset of e in mobility that is consulted, on Post fall to eation was notified. ent Coordinator ervice and refer on the when new or change in o do a ment on a resident acute pain and or all the physician cumenting and and if change in	
	8/17/16 - Admissi including Alzhelm	ion to the facility with diagnoses er's Disease,		condition notify the phys 4. The Director of Nursir		

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	А. В	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURV COMPLETE	
		085033	D. V	/ING	06/14/	2017
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DE	8.7
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F157	documented R2 vimpaired, walked supervision by stareceive any schedand R2 did not had documentation of 3/14/17 and time order by prescribe hip, two views to 3/14/17 and time E5 (LPN), docume holding on to her room and R2 was any difficulties ear assessed by E4 (I was made aware hip to rule out a from the first leg. E4 vecomplete a compressible was made aware hip to rule out a from the first leg. E4 vecomplete a compressible R2 was sitting before dinner, appending R2 was sitting bef	erly MDS Assessment was severely cognitive in room and unit with aff. In addition, R2 did not duled or PRN pain medication are any sign of pain or any pain within the last 5 days. d 9:49 PM - A telephone verbal er, E10 (MD) for x-ray of the rule out a fracture. d 9:52 PM - Progress Note, by ented R2 was very tearful and left hip sitting in the dining ambulating on the unit without rilier this shift. R2 was RN supervisor) and E9 (NP) and ordered an x-ray of the left	F157	will audit nursing documentation of physician when has acute pain and or change and audit that a comprehension assessment was completed. Post fall nurses documentation evaluating the resident and if condition the physican was not these audits will be conducted appropriate monthly times 2 in the conducted of the conducted appropriate monthly times 2 in the conducted appropriate. The conducted appropriate monthly times 2 in the conducted appropriate. The conducted appropriate monthly times 2 in the conducted appropriate. The conducted appropriate monthly times 2 in the conducted appropriate monthly t	a resident In mobilitity on Is a change in otified d daily times reeks, then if nonths. I be rance and eview and mmittee will	
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNAT	URE			

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	A.B	MULTIPLE CONSTRUCTION UILDING /ING		
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP 5651 LIMESTONE ROAD WILMINGTON, DE 19808	CODE	
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F157	verbalized that sithat R2 was cryin 6:00 PM. E5 obsher left thigh. E5 contacted E4 and thereafter. E5 recrying at some pobed around 9:00 and E5 proceeder recalled a reasse by E4. In addition to the resident mover and recommend of 3/15/17 at approximately with E1 verbalized that six R2 was independent and R2 was independent and R2 that six results soon after order was committed the hospital for the comprehensive of performed on the and R2 had a chaphysician should 6/14/17 at approximately with E9 that she is not far recall the specific was provided the however, if a resionset of pain, in the would be to order would be	presence of E2 was held. E5 ne was notified by E7 (CNA) ng after dinner at approximately served R2 crying and rubbing verbalized that she had d E4 had assessed R2 soon ported that R2 had stopped bint and when R2 was put into PM, R2 started to cry again d and contacted E4 and E5 ssment of R2 was completed n, E9 (NP) was contacted due boaning in bed and an order for	F157			

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION	(X3) DATE SURV	
		085033	B. WI	NG	06/14/	2017
	OVIDER OR SUPPLIER ARE HEALTH SERV	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP COI 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DE = 7	-
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F157	comprehensive of the thigh area wo rotation, length or complete this ass R2's refusal and ability to bear we after taking a couexpected that R2 consulted.	page 6 was held. E2 verbalized a linical assessment of pain in build include range of motion, f leg. When E4 was unable to essment on 3/14/17 due to E4 observed change in R2's ight and had to quickly sit down ple of steps, E2 would have 's attending physician be d on 6/14/17 at approximately (NHA), E2, E3 (QAC), and E14	F157			
F225 SS=D	who- (i) Have been fou exploitation, misa mistreatment by a (ii) Have had a fin nurse aide registrexploitation, mistrespropriation (iii) Have a disciplination or her profess licensure body as neglect, exploitation misappropriation (4) Report to the S	EPORT NDIVIDUALS cility must- otherwise engage individuals and guilty of abuse, neglect, ppropriation of property, or	F225	It is the practice of the facility to (3) Not employ or otherwise en individuals who- (i) Have been found guilty of a neglect, exploitation, misapproproperty, or mistreatment by a (ii) Have had a finding entered State nurse aide registry concabuse, neglect, exploitation, mof residents or misappropriation property; or (iii) Have a disciplinary action against his or her professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation mistreatment of residents or misappropriation of resident professional state licensure body as a resure of abuse, neglect, exploitation and the professional state licensure body as a resure of abuse, neglect, exploitation and the professional state licensure body as a resure of abuse, neglect, exploitation and the professional state licensure body as a resure of abuse, neglect, exploitation and the professional state licensure body as a resure of abuse, neglect, exploitation and the professional state licensure body as a resure of abuse, neglect, exploitation and the professional state licensure between the professional state licensure	buse, priation of court of law; Into the erning istreatment in of their in effect license by a lt of a finding roperty. Ide registry by lide registry by against an	7/20/17

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	A. BI	MULTIPLE CONSTRUCTION UILDING ING	(X3) DATE SURV COMPLETE C 06/14/	Ď
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP COD 5651 LIMESTONE ROAD WILMINGTON, DE 19808	L	
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F225	which would Indianurse aide or oth (c) In response to exploitation, or m (1) Ensure that all abuse, neglect, e including injuries misappropriation reported immedia after the allegation cause the allegation of the events that callegation in the events that callegation is in (2) Have evidence thoroughly investigation is in (4) Report the responsition is in (4) Report the responsition is in the administrator or in representative an accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMED:	t of law against an employee, cate unfitness for service as a er facility staff. allegations of abuse, neglect, istreatment, the facility must: If alleged violations involving exploitation or mistreatment, of unknown source and of resident property, are stely, but not later than 2 hours in is made, if the events that ion involve abuse or result in any, or not later than 24 hours if ause the allegation do not do not result in serious bodily inistrator of the facility and to studing to the State Survey, protective services where is for jurisdiction in long-term accordance with State law ed procedures. That all alleged violations are gated. If potential abuse, neglect, istreatment while the	F225	for service as a nurse aide or of staff. (c) In response to allegations of neglect, exploitation, or mistrest facility must: (1) Ensure that all alleged violational involving abuse, neglect, exploitational involving abuse, neglect, exploitational involving abuse, neglect, exploitational involving abuse, neglect, exploitational involving abuse after the allegation involve after the allegation involve abuse or respondity injury, or not later than 2 the events that cause the allegational involve abuse and do not result bodily injury, to the administrational facility and to other officials (in the State Survey Agency and approtective services where state provides for jurisdiction in long facilities) in accordance with State of all involved investigation is in progress. (2) Have evidence that all allegational in progress. (3) Prevent further potential abunealect, exploitation, or mistrest the investigation is in progress. (4) Report the results of all involved the administrator or his or he designated representative and officials in accordance with State including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including to the State Survey Awithin 5 working days of the including the state Survey Awithin 5 working days of the including the stat	of abuse, atment, the ations oltation or a of unknown fresident ately, but not gation is the ult in serious or of the cluding to adult a law -term care tate law s. atment while estigations or other ate law, ogency, cident, and if appropriate	

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1,) MULTIPLE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		085033		VING	06/14/	2017
1	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DDE	n n
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F225	review of other faindicated, it was of failed to thorough unknown origin wallegation of neglisampled resident to thoroughly investion one (R4) out of Findings include: The surveyor was documentation by facility's investigation. The facility's poliant Abuse, Neglect, Embland investigation, it incomplete investigation, it incomplete investigation, it incomplete investigation. Conducting Investigations. Problem identifications. Conducting Investigations. Review of these diregarding who should be investigation. Review of the incomplete investigation of the incomplete incomp	review, staff Interviews, and cility documentation as determined that the facility ly investigate an injury of thich had a potential for an ect for one (R2) out of six s. In addition, the facility failed estigate an allegation of abuse of six sampled residents. In provided the following two the facility, in reference to the tive process: In equition, Mistreatment and Prevention indication for the cluded seven steps: eation; Report; Establish Facts; gate; Evaluate and Expand' and Document. In stigations-Skilled Nursing tionWho will be courseled to interviewed, during the envestigation and the facility's	F225	1. 1.R2 no longer resides in the 2.The Director of Nursing and will conduct random audits of and incidents in last 30 days the facility did conduct a thorn investigation including parties the incident are interviewed a statement obtained. 3. The Quality Assurance Core-educate the Interdisciplina the "8 steps of conductin an investigation. (attached) The Staff Development Coo or Designee will inservice the nursing staff on obtaining with statements of parities involed incident. 4. The Director of Nursing and will conduct random audits of and incident reports in the last evaluate the facility did a thorn investigation. The Director of or designee will audit new reach and neglect to evaluate thorough investigation and pathave been interviewed and we statements obtained prior to the follow up being submitted to the These audits will be conducted than weekly x2, than if approprimes 2 months.	or designee reportables o evaluate bugh involved in and witness insultant will by team on effective dinator and licensed ess in the licensed est involved ess involved thess involved thess in estate. In daily x5, riate monthly	

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		· 085033	B. WING		C 06/14/2	2017
,	OVIDER OR SUPPLIER ARE HEALTH SERV	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP COD 5651 LIMESTONE ROAD WILMINGTON, DE 19808	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X6) COMPLETE DATE
F225	new onset of left 11:00 PM shift or called MD. Left of showed fracture and order to send completed by E1 signed by E1 (Nh The investigation cause of the fract had no falls or included interviewed E6 (during the 3:00 PM of 13/17 at approximately 3:14/17. E6 recay wheelchair at the approximately 3:14/17. E6 recay wheelchair at the approximately 3:14/17. Some found sitting on the secured unit E7 [CNA] was informed by investigation has verbalization that 3/14/17. As this verbalization that 3/14/17. As this verbalization that 3/14/17. As this verbalization that 3/14/17 and the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility's deall parties who need the secure of the faconducting their is above facility of the faconducting the faconducting their is above facility of the faconducting the fa	page 9 ented that R2 complained of hip pain during the 3:00 to a 3/14/17, RN assessed and cray ordered and results of the left hip. NP was notified it to ER. The investigation was 3 (RN, UM) on 3/18/17 and HA) and E2 (DON) on 4/10/17. was unable to determine the ture and documented that R2 cident on 3/14/17. This ited evidence that the facility CNA), who was assigned to R2 M to 11:00 PM on 3/14/17. Identify 12:10 PM, an interview ducted in the presence of E2. It she was the assigned CNA for 10 PM - 11:00 PM shift on 11ed that R2 was in a beginning of the shift and at 50 PM, when E6 took R2 to the tood up, so that the adult brief id, R2 had pain and E6 informed time after 8:00 PM, R2 was ne floor in the dining room in and E6 informed E5. E6 and structed to pick up the resident are the resident in the lace R2 in the bed. Identify 10:00 AM, the surveyor E1 [NHA], that a new been initiated due to E6. R2 was found on the floor on was new information for the cility did not interview E6 while nvestigation previously. The bedeed to be interviewed noident involving an injury of	F225	forwarded to the Quality Assura. Assessment Committee for revaction as appropriate. The Condetermine need for further audiaction. 2. 1. R4 does reside in the facility of abuse and neglect 2. The Director of Nursing and will conduct random audits in late to evaluate the facility did conditional thorough investigation including involved in the incident are interested that any allegation of abuse and are thoroughly investigated. 3. The Quality Assurance Considereducate the Interdisciplinary the "8 steps of conducting an investigation. (attached) The Staff Develop Coordinate Designee will inservice the lice nursing staff on obtaining withe statements of parties involved Incident and to thoroughly investigations of abuse and negled. 4. The Director of Nursing and will conduct random audits of rand incident reports in the last evaluate the facility did a thorought investigation. The Director of Nordesignee will audit new reports and neglect to evaluate thorough investigation and parhave been interviewed prior to follow up being submitted to the These audits will be conducted.	whew and mittee will its and/or and is free or designee est 30 days luct a granties erviewed and id neglect sultant will ream on effective or and or insed est in the estigate any ect. or designee reportables 30 days to ugh lursing and or it has had a ties involved the 5 day se state.	

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING	LDING	
		085033	B, V	VING	06/14	(1)
	ROVIDER OR SUPPLIER	/ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP O 5651 LIMESTONE ROAD WILMINGTON, DE 19808	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE	(X5) COMPLETE DATE
F225	4:00 PM with E1, 2. Review of the records for R4 re 3/30/17 through 4 documented that physical abuse of 8:00 PM and 9:00 reported observir against the wall, i around while proving the record of the province of the phim. Before cooperative, E7 picare without E15 documented that substantiate the \$6/6/17 at approximal province of the phim of	d on 6/14/17 at approximately E2, E3 (QAC), and E14 (ICP). Investigation and the facility's vealed: 4/1/17 - Incident Report the incident of an allegation of courred on 3/29/17 between PM, in which R4's son ag E7 (CNA) pushing R4's hand in the bathroom, to turn R4 yiding Incontinence care and Review E7's statement called for E15 [CNA] to come E15 came, since R4 was proceeded with incontinence The facility's conclusion the facility was unable to allegation of abuse.	F225	weekly times 1, then 2 times 2 than if appropriate monthly months. The results of these audit with to the Quality Assurance and Committee for review and a appropriate. The Committee need for further audits and/or	Il be forwarded d Assessment action as will determine	
F309 S8=G	had placed a teleto obtain a witnes not return the call interviewed. E2 of the facility on 3/30 the investigation vot interviewed as Findings reviewed 4:00 PM with E1, 483.24, 483.25(k)	l on 6/14/17 at approximately E2, E3, and E14.	F309	It is the practice of the facility	v that Quality	7/20/17
	483.24 Quality of			of life is a fundamental princ applies to all care and servic facility residents. Each resid	iple that es provided to	

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING	(X3) DATE SURV COMPLETE	
		085033	B. W	ING	06/14/	2017
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DE	
(X4) ID PREFIX TAG	(EACH DEFIÇIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
F309	applies to all care facility residents. and the facility mand services to a practicable physically being, consistent and services.	page 11 fundamental principle that a and services provided to Each resident must receive ust provide the necessary care ttain or maintain the highest cal, mental, and psychosocial stent with the residents ssessment and plan of care,	F309	receive and the facility must perfect necessary care and services maintain the highest practical mental, and psychosocial we consistent with the residents comprehensive assessment a care.	to attain or ble physical, I-being,	
	applies to all trea facility residents. assessment of a ensure that reside in accordance with practice, the com	a fundamental principle that tment and care provided to Based on the comprehensive resident, the facility must ents receive treatment and care the professional standards of prehensive person-centered e residents@hoices, including		Quality of care is a fundament that applies to all treatment a provided to facility residents. comprehensive assessment of the facility must ensure that receive treatment and care in with professional standards of comprehensive person-cente and the residents@hoices, inclimited to the following:	nd care Based on the of a resident, esidents accordance f practice, the red care plan,	
	is provided to res services, consiste of practice, the co	ment. ensure that pain management idents who require such ent with professional standards imprehensive person-centered e residents@oals and		(k) Pain Management. The facility must ensure that management is provided to re require such services, consist professional standards of pracomprehensive person-center and the residents goals and professional standards.	esidents who tent with ctice, the red care plan,	it.
	residents who req services, consiste of practice, the co	acility must ensure that juire dialysis receive such ent with professional standards imprehensive person-centered e residents@oals and		(I) Dialysis. The facility must or residents who require dialysis services, consistent with profistandards of practice, the corperson-centered care plan, a residents@oals and preference.	receive such essional nprehensive nd the	
	This REQUIREME by:	ENT is not met as evidenced		R2 no longer resides in the The Director of Nursing and	j	
	review of other fac	review, staff interviews, and cility documentation as letermined that for one (R2) of		2.The Director of Nursing and will do random audits of the random sudits of the random sudits of the random sudits of the resident has a new onset of a	esidents when a	

AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING	COMPLETE	
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NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
MANORO	ARE HEALTH \$ERV	ICES - PIKE CREEK		5851 LIMESTONE ROAD WILMINGTON, DE 19808		
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F309	provide the necessive resident to attain and mental well-k onset of acute particular change in mobility ambulation to require failed to conduct assessment, inclustive facility failed to not new onset of acute mobility status. A negative vocalization of the first identificate showed R2 had a inconsistent document that report. Add (LPN) and E4 (RN a lack of document that occurred on accurate investigation by R2. Findings in The pain manage the American Gerinoluded: approprimanagement of pacilitates regular same quantitative should be used fo assessment; set intervention; and deffectiveness and management. Review of facility provides in the supposition of pacilitates regular same quantitative should be used for assessment; set intervention; and deffectiveness and management.	dents, the facility failed to ssary care and services for the her highest level of physical being. R2 experienced a new in of the left thigh and a y status from independent juring a wheelchair. The facility a comprehensive clinical juding pain assessment. The otify the physician about the te pain and change in R2's although R2 was displaying tion of pain, as evidenced by ng, the facility failed to provide or approximately 11 hours after ion of pain. An x-ray later broken hip. There is mentation in the clinical record and left hip and consequently litionally interviews with E5 N) recorded below demonstrate intation regarding the events 8/14/17 which inhibited an action of the trauma sustained	F309	or change in mobilty that the at physician is consulted. Review nursing documentation validate the proper evaluation of completed and documnetation change in condition the physical notified. - The Director of Nursing and of will do random audits of resider ensure that the clinical record is and accurate. - The Director of Nursing and of will do random audits of resider notes to evaluate the nurses and documenting accurately with the assessment stating the time it. - The Director of nursing and or will do random audits of resider notes to evaluate the nurses and documenting that pain medicating administered timely. 3. The Staff Developement Cocand or designee will inservice a educate the Nursing staff on: Consulting a physician when neacute pain and or change in modulate the pain and or change in modulate that has a new onset of acute perhange in mobility consult the period of the resident and if change in mobility consult the period of the resident and if change in mobility the physician.	a Post fall to was and if an was and if an was are designed at scharts to a complete at sprogress e e e e e e e e e e e e e e e e e e	
LABODATOON	DIRECTORIS OF BROWN	RISUPPLIER REPRESENTATIVE'S SIGNAT	1100			

	CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A. 8UIL	ULTIPLE CONSTRUCTION DING	COMPLETE	
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(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F309	about their pain. converted to num absence of pain a pain. This may in to complete the p impairment or car The non-specific suggest the prese (crying, moaning, guarding), resistir in galt, loss of fun - Obtain pain scal after administratio Review of R2's cli 8/17/16 - Admissi including Alzheim 8/17/16 - Physicia Tylenol every 4 ho 12/28/16 - Quarte dooumented R2 w impaired, walked is supervision by sta receive any sched and R2 did not ha documentation of 1/23/17 - Care pla arthritis left hand 4 that R2 will expres within acceptable to report nonverba moaning, striking of thrashing, change	The observations are seric score with "0" being and "10" as being the worst clude patients who are unable all interview, have cognitive mot verbally communicate. signs and symptoms that may ence of pain include vocal groaning), rubbing (bodying movement or care, change ction. It is escores daily and before and on of PRN pain medication. In the facility with diagnoses er's Disease. Instrument or pain. In y MDS Assessment was severely cognitively in room and unit with lift. In addition, R2 did not littled or PRN pain medication we any sign of pain or any pain within the last 5 days. In problem for pain related to the facility. Interventions included all expressions of pain such as put, grimacing, crying,	F309	or designee will inservice the non completing and documenting comprehensive assessments of who have new on set of acute inservice the nursing staff on finanagement guidelines to inclimedicating the resident timely, the resident using the pain marguidelines, to medicate resident needed base on the pain assess to re-assess after the pain medigiven using the pain assessment guidelines to assure medication. The Staff Development Coordor designee will inservice the non accurate documentation, co assessments and stating the three assessment in their notes and will audit nursing documentation notification of physician when a has acute pain and or change if and audit that a comprehensive assessment was completed. The will be conducted daily times 5 weekly times 2 weeks, then if a monthly times 2 months. The Director of Nursing and of will conduct audits in the Eagle nursing progress notes to evaluate pain and that pain medical given timely to the resident. Point nurses are documenting and either resident and if change in or the resident and if th	g an acurate on residents pain. acility pain ude to assess nagement at timely if asment and liation is not effective. Ilinator and ursing staff implete me of the what or designee in to validate in resident in mobility enese audits days, then appropriate or designee room of liate the nensive ew onset of ation is st fall, validing	
Control of the Contro	CIDEOTANIA DE BEGUIERE	PARTIED DEPRESENTATIVE'S SIGNATI	Lete ex			

STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10	LTIPLE CONSTRUCTION DING	(X3) DATE SURV COMPLETE	
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	OVIDER OR SUPPLIER ARE HEALTH SERV	/ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808		ad t)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F309	Summary docum of "0" indicating in statement noted I during tolleting. No new onset of pair 3/14/17 and time order by prescribe hip, two views to 3/14/17 and time E5 (LPN), docum holding on to her room [exact time ambulating on the earlier this shift. I supervisor) and E ordered an x-ray of fracture. Although documented that record review lack comprehensive as pain. 3/14/17 - 3:00 PM Administration Re any administration Re any administration Re any administration Re any administration Re continip pain. R2 continip pain. R2 continip pain. R2 continip pain pending retime. (An interview E8 confirmed this in reference to the documentation of the state of the state of the documentation of the state of t	d 3:56 PM - The Pain Level ented that R2 had a pain scale to pain. However CNA [E6] R2 expressed pain at 3:50 PM to further assessment of R2's in was noted. d 9:49 PM - A telephone verbal er, E10 (MD) for x-ray of the rule out a fracture. d 9:52 PM - Progress Note, by ented R2 was very tearful and left hip sitting in the dining not documented] and R2 was e unit without any difficulties R2 was assessed by E4 (RN to (NP) was made aware and of the left hip to rule out a in this progress note R2 was assessed by E4, sed evidence of a essesment of the new acute to 11:00 PM shift, Medication cord (MAR) lacked evidence of in of PRN Tylenol for pain. 3:27 AM - Progress Note, by PM - 7:00 AM shift, nues to monitor VS and right inues with signs and when her legs are moved and in the AM. PRN Tylenol given esults. Denies pain at this in [6/19/17 at 10:30 AM] with documentation was accurate, right hip pain, despite other	F309	physican was notified These audits will be conducted 5 days, then weekly times 2 we then if appropriate monthly time The Director of Nuring and or will audit nursing progress note Eagle room meeting to evaluate are documenting the time of wh occured. These audits will be of daily x5, then weekly times 2, the appropriate monthly time 2 months The results of these audits will forwarded to the Quality Assura Assessment Committee for reveation as appropriate. The Com determine need for further audit action	designee s in the e the nurses ich incident onducted nen if inths.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	1100	085033	B, W	ING	06/14/	2017
	OVIDER OR SUPPLIER	ICES - PIKE CREEK	-	STREET ADDRESS, CITY, STATE, ZIP C 5651 LIMESTONE ROAD WILMINGTON, DE 19808	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F309	Summary docum of "5" indicating in 3/15/17 and times E8 documented Tright hip pain with (An interview with documentation with hip pain). 3/15/17 - MAR do as administered of 3/15/17 - 11:00 P documented "E" if the post pain assess facility failed to util 10 scale) for reastrather than the nutificality policy. 3/15/17 and times E8 documented the effective with R2 with post pain assessment. 3/15/17 and times E11 (LPN), documented E11, documented PM for pain score moderate level of	d 3:30 AM - The Pain Level ented that R2 had a pain scale noderate level of pain. d 3:30 AM - Progress Note, by Tylenol given for complaint of a pain score of 5 out of 10. E8 confirmed this as accurate, in reference to the complaints of pain in hip. M - 7:00 AM shift, MAR ndicating effective. Although essment indicated effective, the illize the same pain scale [0 to sessment of the intervention, americ scale as required by the same scale for post with no S/S of pain, able to hout moaning. Although the ment indicated effective, the illize the same scale for post indicated that R2 remains in bed at and awaiting x-ray to left hip. 1 12:03 PM - Progress Note, by Tylenol administered at 12:03 of 4, indicating mild to	F309			
	and the second	12.70 1 171 1710 1 201 20701				

Facility ID; DE00145

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NULTIPLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
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	ROVIDER OR SUPPLIER CARE HEALTH SERV	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP COD 5651 LIMESTONE ROAD WILMINGTON, DE 19808	6	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X6) COMPLETE DATE
F309	of 4, indicating m 3/15/17 - 7:00 AN documented "U" i effectiveness of ti administered at 1 3/15/17 and timed E11, documented was seen by E12 Tramadol PRN fo 3/15/17 and timed E11, documented of x-ray return. R medicated as ord PM). No bruising of pain when turni 3/15/17 and timed E11, documented to NP and NP ord evaluation and 91 3/15/17 and untim (PA), documented nursing to see pat with ambulation ar to pain. There is r VS BP 119/65, P exam, noted decre tenderness of hip ray, Tramadol PRI of this progress no the x-ray, as a frac displacement [out send R2 to the em	ented that R2 had a pain scale illd to moderate level of pain. I - 3:00 PM shift, MAR indicating unknown, as to the ne pain relief, from the Tylenol 2:03 PM. I 1:50 PM - Progress Note, by I x-ray results pending and R2 (PA) and gave new orders for moderate to severe pain. I 1:51 PM - Progress Note, by R2 remains in bed until results 2 given meals in bed. R2 ered for pain (Tylenol at 12:03 noted to left hip, R2 complaining in bed. I 2:28 PM - Progress Note, by results of left hip x-ray given ered to send to ER for 1 called. ed Progress Note, by E12 that E12 was asked, by lent who is having difficulty ind holding left thigh secondary no documented witnessed fall. 100, R 18, T97.6 F. Upon lease ROM of left hip with and thigh. Plan included x-N every 6 hours. On the back of the commented the results of other with moderate of alignment] and plan was to	F309			
	documented that the	ne 911 call was received at 2:	I I Brad			

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 06/14/2017 085033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5651 LIMESTONE ROAD** MANORCARE HEALTH SERVICES - PIKE CREEK WILMINGTON, DE 19808 (XS) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F309 F309 Continued From page 17 33 PM and R2 arrived at the hospital at 3:14 PM. 6/8/17 at approximately 3:00 PM, an interview with E4 [RN Supervisor] in the presence of E2 (DON) was held. E4 verbalized that she was notified by E5 [LPN] that R2 was crying and rubbing her left leg. E4 verbalized that she attempted to complete a comprehensive physical assessment while R2 was sitting in the dining room chair before dinner, approximately 4:30 PM to 5:00 PM, however, R2 resisted and E4 was unable to complete the assessment. E4 reported that R2 attempted to take a couple of steps but quickly sat down on the chair and became tearful. E4 related that she instructed E5 to administer Tylenol and monitor R2's condition. E4 indicated that she had left early during that shift before 8:00 PM and she did not have any further contact with R2 on 3/14/17. E4 related that she did not notify R2's attending physician. 6/8/17 at approximately 3:15 PM, an interview with E5, in the presence of E2 was held. E5 verbalized that she was notified by E7 (CNA) that R2 was crying after dinner at approximately 6:00 PM, E5 observed R2 crying and rubbing her left thigh. E5 verbalized that she had contacted E4 and E4 had assessed R2 soon thereafter. E5 reported that R2 had stopped crying at some point and when R2 was put into bed around 9:00 PM, R2 started to cry again. E5 proceeded and contacted E4 [RN Supervisor] and E6 recalled a reassessment of R2 was completed by E4. In addition, E9 [NP] was contacted due to the resident moaning in bed. 6/8/17 at approximately 3:55 PM, an interview with E7 [CNA], in the presence of E2 was held. E7 verbalized that he was not the assigned CNA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF OORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	
F309	rather E6 (CNA) confirm that E7 in while sitting in the dinner on 3/14/17 he assisted E6 in bed at approxima unable to do so a activity. E7 verba was independent bed. 6/13/17 at approx with E6 (CNA) was of E2. E6 confirm CNA for R2 during on 3/14/17. E6 re wheelchair at the approximately 3:5 toilet. When R2 st could be removed E5 (LPN). Sometifound sitting on the secured unit a E7 (CNA) were infrom the floor, play wheelchair and play verbalized that R2 remembered that over to the right si made aware that 1 crying. E6 reported approximately two incontinence care 6/13/17 at approximately two incontinence care for E2 (DON). E5 verbalized that R2 recollection that R2 thus, it was E5's donot a sign of R2 extends the sit	3:00 PM - 11:00 PM shift but was the assigned CNA. E7 did afformed E5 that R2 was crying, edining room chair before. In addition, E7 reported that turning and repositioning R2 in stely 8:00 PM since R2 was and was crying during this alized that prior to this date, R2 in turning and repositioning in standard that she was the assigned gothe 3:00 PM - 11:00 PM shift exalled that R2 was in a beginning of the shift and at 50 PM, when E6 took R2 to the tood up, so that the adult brief I, R2 had pain and E6 informed ime after 8:00 PM, R2 was see floor in the dining room in and E6 informed E5. E6 and estructed to pick the resident up to the resident in the ace R2 in the bed. E6. Was placed in bed and R2 was crying and hunched de of the bed. Again, E5 was R2 was experiencing pain and ed that she checked on R2 hours afterwards and no was needed at that time. Imately 3:15 PM, a subsequent was conducted in the presence verbalized that it was her 2 had a behavior of crying, etermination that crying was experiencing pain and PRN	F309				
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATI	IRE				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B, WING		(X3) DATE SURVEY COMPLETED C 06/14/2017	
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F309	from 3:00 PM to was found on the 6/14/17 at approximaterized that stresults soon after order was commute hospital for the comprehensive operformed on the and R2 had a chaphysician should 6/14/17 at approximative with E9 verbalized that shoes not recall that she was provabled to fracture. 6/14/17 at approximative with E9 verbalized that she was provabled that she was provabled that she was provabled to fracture. 6/14/17 at approximative class with E2 [DON] was comprehensive class at the she was provabled to fracture. 6/14/17 at approximative class at the she was provabled to fracture. 6/14/17 at approximative class at the she was provabled to facture. 6/14/17 at approximative class at the she was provabled to facture. 6/14/17 at approximative class at the she was provabled to facture. 6/14/17 at approximative class at the she was provabled to facture. 6/14/17 at approximative class at the she was provabled to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture. 6/14/17 at approximative class at the she was provable to facture.	page 19 administered during her shift 11:00 PM. E5 denied that R2 afloor after dinner on 3/15/17. In the thigh pain. E12 In the was made aware of the x-ray of the assessment of R2 and an unicated to send the resident to eatment. E12 verbalized if a linical assessment could not be evening of 3/14/17 by a RN, ange in mobility, R2's attending have been contacted. In the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and e specifics of the information of the thigh area, her is not familiar with R2 and expecifics of the information of the thigh area, her is not familiar with R2 and the to order an x-ray to rule out a limitally 2:20 PM, an interview is held. E2 verbalized a inical assessment of pain in uld include range of motion, leg. When E4 [RN inable to complete this 14/17 due to R2's refusal and inge in R2's ability to bear quickly sit down after taking it would have expected that yellow be notified. E2	F309			

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(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 085033 06/14/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5651 LIMESTONE ROAD MANORCARE HEALTH SERVICES - PIKE CREEK WILMINGTON, DE 19808. (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F309 Continued From page 20 F309 confirmed that pharmacological intervention of Tylenol was not administered, as instructed by E4 and as ordered by R2's attending physician, during the 3:00 - 11:00 PM shift, when R2 was displaying signs and symptoms of pain, which included crying and moaning. Additionally, E2 confirmed no VS were completed during this shift. 6/19/17 approximately 10:30 AM, a telephone interview with E8 [LPN] revealed that his recollection was that R2 was experiencing pain in the right hip, as evidenced by moaning when her legs were moved while she was in bed during the 11:00 PM to 7:00 AM shift on 3/15/17. The facility failed to: -conduct a comprehensive clinical assessment, including pain assessment when R2 developed a new onset of acute left thigh pain in conjunction with a change in mobility status. -failed to provide pain medication for approximately 11 hours after the first identification of pain. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1 (NHA), E2 [DON], E3 (QAC), and E14 (ICP). F441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, It is the practice of the facility to: 7/20/17 F441 PREVENT SPREAD, LINENS (a) Infection prevention and control SS=D program. (a) Infection prevention and control program. The facility must establish an infection The facility must establish an infection prevention and control program (IPCP) that prevention and control program (IPCP) that must must include, at a minimum, the following include, at a minimum, the following elements: elements: (1) A system for preventing, identifying, (1) A system for preventing, identifying, reporting, investigating, and controlling reporting, investigating, and controlling infections and communicable diseases for all infections and communicable diseases for LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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NAME OF PROVIDER OR SUPPLIER MANORGARE HEALTH SERVICES - PIKE CREEK (XAI) D. (XAI)	STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BI	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURV COMPLETE	D
MANORGARE HEALTH SERVICES - PIKE CREEK DATE DATE SUMMARY STATEMENT OF DEFICIENCIES RECOUNTRY OF USE DETERMINED NOT PUBLIC DATE DATE			085033	B. W	MNG	06/14/	2017
F441 Continued From page 21 residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based pracautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (iv) When and how isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct context with residents or the facility must prohibit employees with a communicable disease or infected skin lesions from direct context with residents or their food, if direct to context with residents or their facility must prohibit employees with a communicable disease or infected skin lesions from direct context with residents or their facility must prohibit employees with a communicable disease or infected skin lesions from direct context with residents or their facility must prohibit employees with a communicable disease or infected skin lesions from direct context with residents or their facility must prohibit employees with a communicable disease.			/ICES - PIKE CREEK		5651 LIMESTONE ROAD	DDE	
residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the Isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the Isolation should be the least restrictive possible for the resident under the circumstances under which the facility must prohibit employees with a communicable disease or infectious send to the residents or their food, if direct contractival arrangement based upon the facility assessment conducted according to contractual arrangement based upon the facility assessment conducted according to contractual arrangement based upon the facility assessment conducted according to contractual arrangement based upon the facility assessment conducted according to contractual arrangement based upon the facility assessment conducted according to contractual arrangement based upon the facility assessment conducted according to chast. 433, 70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to the identify possible communicable disease or infections before they can spread to other persons in the	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF!>	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE
contact will transmit the disease; and communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the	F441	residents, staff, vindividuals provide contractual arran assessment condand following acc (facility assessment condand following acc (facility assessment condand for the program, vimited to: (i) A system of suppossible communication of the program, vimited to: (ii) A system of suppossible communication of the program of the provided; (iii) When and to vice communication of the provided; (iii) Standard and precautions to be infections; (iv) When and ho a resident; included the circums of the least restrictive under the circums of the circums of the prohibit emplification of the circums of the prohibit emplies asse or infected contact with resident of the circums of the	rolunteers, visitors, and other ting services under a gement based upon the facility ducted according to 483.70(e) cepted national standards ent implementation is Phase 2); ands, policies, and procedures which must include, but are not urveillance designed to identify nicable diseases or infections spread to other persons in the whom possible incidents of sease or infections should be transmission-based followed to prevent spread of w isolation should be used for ing but not limited to: duration of the Isolation, the infectious agent or d, and t that the Isolation should be re possible for the resident stances. Inces under which the facility ployees with a communicable and skin lesions from direct ents or their food, if direct ents or their food, if direct ents or their food, if direct ents the disease; and	F441	all residents, staff, volunteers other Individuals providing secontractual arrangement bas facility assessment conducted 483.70(e) and following accestandards (facility assessment implementation is Phase 2); (2) Written standards, policies procedures for the program, include, but are not limited to (i) A system of surveillance didentify possible communication infections before they can other persons in the facility; (ii) When and to whom possition of communicable disease or should be reported; (iii) Standard and transmission precautions to be followed to spread of infections; (iv) When and how isolation sused for a resident; including limited to: (A) The type and duration of depending upon the infectiou organism involved, and (B) A requirement that the is be the least restrictive possib resident under the circumstant (v) The circumstances under facility must prohibit employe communicable disease or infelesions from direct contact with the	rvices under a ed upon the di according to pted national of the discording to pted national of the discording to pted national of the discording to pted discording to ple discording to ple incidents and the isolation, and the isolation, are agent or pleation should be for the inces. Which the es with a perted skin the residents or present the isolation should be for the inces.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: YOAZ11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033		(X2) MULTIPLE CONSTRUCTION . A. BUILDING		(X3) DATE SURVEY COMPLETED C 06/14/2017		
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP C 5651 LIMESTONE ROAD WILMINGTON, DE 19808		2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
F441	(4) A system for runder the facility actions taken by (e) Linens. Perso process, and tran the spread of infe (f) Annual review annual review of program, as necestally facility failed to enterniques during [SSR1] out of one include: Review of the Heroperator's Manual glucose monitoring Cleaning and disineach patient and Dispatch Hospital Bleach. During medication SSR1 on 6/6/17 at (RN) used the Evolution blood from glucometer, E16 put the medication can disinfecting the designations actions to the medication can disinfecting the designations actions a	recording incidents identified an IPCP and the corrective the facility. Income must handle, store, asport linens so as to prevent action. The facility will conduct an lits IPCP and update their	F441	disease; and (vi) The hand hygiene proces followed by staff involved in a contact. (4) A system for recording in identified under the facilityal corrective actions taken by the corrective actions taken by the corrective actions taken by the facility an annual review. The facility an annual review of its IPCP their program, as necessary, the facility 1. The gluccometer was dising immediately with dipatch wip The nurse was given one or education 2. The Director of Nursing an will conduct audits of resider glucometer use to evaluate the machine is being cleaned im use with a dispatch wipe. 3. The Staff Development Coor design will inservice the nurse infection control processed in the	cidents PCP and the ne facility. andle, store, a so as to on. will conduct and update the practice of affected es n one d or designee the glucometer mediately after cordinator and urses on edure er use for ment and or lutions of estrating how neter after	

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURV	/EY
		085033		/ING	06/14/	2017
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 5651 LIMESTONE ROAD WILMINGTON, DE 19808	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
F441 F514 SS=D	Continued From E16 confirmed the of the device was 6/6/17 at approxi with E14 (ICP) or must be cleaned Dispatch Hospital Bleach before us Findings reviewe 4:00 PM with E1 and E14. 483.70(i)(1)(5) RI COMPLETE/ACC (i) Medical record (1) In accordance standards and primaintain medical are- (i) Complete; (ii) Accurately doc (iii) Readily access (iv) Systematically (5) The medical record of the first of the cord of the first confirmation of the first confirmat	page 23 at no cleaning and disinfecting a completed prior to use. mately 3:00 PM, an interview onfirmed that the glucometer and disinfected, by using I Cleaner Disinfectant with ing the device on a resident. d on 6/14/17 at approximately (NHA), E2 (DON), E3 (QAC), ES RECORDS-CURATE/ACCESSIBLE is. with accepted professional actices, the facility must records on each resident that cumented; esible; and y organized ecord must contain- mation to identify the resident; e resident@assessments; ensive plan of care and	F441	will conduct audits of the resi require glucometer use to ev nurse is following the infectio procedure using the dispatch resident use. This audit will b daily times 5 days, than weel then if appropriate monthly til The results of these audits w forwarded to the Quality Asse Assessment Committee for action as appropriate. The C determine need for further au action	alute the n control wipes post e conducted sty 2 times, ne 2 months. If be arance and eview and ommittee will dits and/or accordance andards and records on conta entify the assessments; of care and mission	8/20/17
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	1		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURY COMPLETE C	D
45		085033			06/14/	2017
	OVIDER OR SUPPLIER	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP C 5651 LIMESTONE ROAD WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F514	and resident revie determinations of (v) Physicians in professionals pro	any preadmission screening aw evaluations and conducted by the State; arsest and other licensed gress notes; and adiology and other diagnostic as required under 483.50. ENT is not met as evidenced areview and staff interview, it that the facility falled to ensure accord for one (R2) out of six as was complete and/or as include: 309. The reviewed in R2's clinical and left hip sitting in the dining ambulating on the unit without rilier this shift. R2 was RN supervisor) and E9 (NP) and ordered an x-ray of the left acture. Although this progress that R2 was assessed by E4,	F514	and determinations conducts State; (v) Physicians nurses and professional progress note (vi) Laboratory, radiology and diagnostic services reports a under 483.50 1. a cross refer F309 1. R2 no longer resides in the 2. The Director of Nursing arwill do random audits of residensure that the clinical record and accurate. 3. The Staff Developement of and or designee will inservice staff on completing and doct accurate comprehensive ascresidents who have new on pain. 4. The Director of Nursing and will conduct audits in the Eanursing progress notes to expurses are doing comprehensive ascendents with acute pain, these audits will daily times 5 days, then were weeks and then if appropriations 2 months. The results of these audits will forwarded to the Quality Assessment Committee for action as appropriate. The Control of	other licensed s; and d other is required e facility d or designee dents' charts to d is complete coordinator e the nursing amenting an essement on set of acute of acute of acute of acute of ending the new on set of be conducted kly times 2 e monthly will be urance and review and	

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STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/\$UPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	NULTIPLE CONSTRUCTION ILDING NG	(X3) DATE SURV COMPLETE	D
		085033	B, WI	, , , , , , , , , , , , , , , , , , ,	06/14/	2017
	OVIDER OR SUPPLIER	/ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP COD 5651 LIMESTONE ROAD WILMINGTON, DE 19808	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F514	was sitting in the dinner, approxim however, R2 resi complete the ass attempted to take sat down on the related that she in Tylenol and moniconfirmed that latthe completed as instructions to ad R2's condition. Findings reviewe 4:00 PM with E1 (ICP). 1b. Cross refer F 3/14/ 17 and time E5 [LPN], docum holding on to her room and R2 was any difficulties ea assessed by E4 [was made aware hip to rule out a fidocumented that holding on to her lacked evidence which this had oc 6/8/17 at approximith E5, in the preverbalized that sh that R2 was cryin 6:00 PM. E5 obsher left thigh. E5 contacted E4 and	chysical assessment while R2 dining room chair before ately 4:30 PM to 5:00 PM, sted and E4 was unable to ressment. E4 reported that R2 a couple of steps but quickly chair and became tearful. E4 instructed E5 to administer liter R2's condition. E4 ck of documentation, related to resessment as well as minister Tylenol and to monitor d on 6/14/17 at approximately (NHA), E2, E3 (QAC), and E14 (NHA), E2, E3 (QAC), and E14 (PS) ambulating on the unit without riler this shift. R2 was RN Supervisor] and E9 [NP] and ordered an x-ray of the left racture. Although E6 R2 was very tearful and left hip, the documentation of the examination time in	F514	determine need for further aud action. 1.b cross refer F309 1. R2 no longer resides in the factor of Nurinig and will do random audits of reside notes to evaluate the nurses at documenting accurately with the assessment stating the time if assessment stating the time if assessments and stating the time assessment in their notes and occurred. 4. The Director of Nuring and will audit nursing progress note Eagle room meeting to evaluate are documenting the time the if occurred. These audits will be dally x5 days, the weekly times appropriate monthly time 2 months and the control of these audits will forwarded to the Quality Assurfaces as appropriate. The Condetermine need for further audit action. 2. 1. R2 no longer resides in the factor of Nursing and will conduct random audits:	facility or designee ents progress re ne t occurred. rdinator and nursing staff omplete me of the what or designee es in the te the nurses ncident conducted a 2, then if onths. be rance and view and mmittee will lits end/or	

Facility ID: DE00145

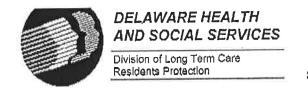
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING	(X3) DATE SURVEY COMPLETED C 06/14/2017	
		085033	B. WING			
	OVIDER OR SUPPLIER ARE HEALTH SERV	ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP 5651 LIMESTONE ROAD WILMINGTON, DE 19808	CODE	= "
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F514	bed around 9:00 proceeded and c reassessment of confirmed that the was not documer as well as R2 cry the bed around 9 Findings reviewe 4:00 PM with E1, 2. 3/15/17 and the and Investigation date and time was description of the location of the incommentative documents on the incommentative documents of left 11:00 PM shift on called MD. Left and order to send completed by E1 (NHThe investigation cause of the fract had no falls or incinvestigation lack interviewed E6 (during the 3:00 Pm 6/8/17 at approximation with E4 [RN Super (DON) was held. Notified by E5 [LP rubbing her left le attempted to comphysical assessment of the true true true true true true true tru	pint and when R2 was put into PM, R2 started to cry again. E5 ontacted E4 and E5 recalled a R2 was completed by E4. E5 e time of R2 crying after dinner need in the above progress note ing again after R2 was put in	F514	-incident reports and or re evaluate there is a thorough of the event and parties invinterviewed and have witne - progress notes to evaluat have notified the physcian vertices to allow a comprehe assessment to be complete reflect consistent and accurdocumentaiton of the event 3. The Quality Assurance Core-educate the Interdiscipling the "8" steps of conducting investigation. (attached) The Staff Development Core-educate the Interdiscipling investigation. (attached) The Staff Development Core-educate the Interdiscipling investigation of abuse and nearly incident and to thoroughly incident and parties involved incidents and or report evaluate there is thorough incidents and parties involved interviewed and have witned the event and parties involved interviewed and have witned the nurses progress notes to evaluate the nurses have physician when the resident allow a comprehensive assistent documentation. The results of these audits of the audit	n Investigation olved are as statements. e the nurses when a resident ansive d and the notes rate consultant will hary team on an effective cordinator and he licensed itness ed in the novestigate any glect amenting so the event and or designee aring progress ortables to novestigation of ed are as statements. Will be audited a notified the trefuses to essment and and accurate	

Facility ID: DE00145

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 06/14/2017	
	OVIDER OR SUPPLIER	085033 ICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CO 5651 LIMESTONE ROAD WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	ON SHOULD BE COMPLETE DE APPROPRIATE DATE	
F514	reported that R2 steps but quickly became tearful. notify R2's attend comprehensive p be completed. 6/8/17 Although notify R2's attend unable to complete incident report an incorrectly docum and called MD" report and investithat the "NP was and order send to the PA (E12). The facility failed have consistent exact location of have sufficient, a ensure a thorough events that occurs ustained a fractive.	attempted to take a couple of sat down on the chair and E4 related that she did not ling physician, when the physician when the shysical assessment could not ling physician when she was the an assessment, the facility's and investigation documentation mented that the" RN assessed Additionally, the incident igation incorrectly documented as notified (of the x-ray results) of ER" since the order was from to: to: documentation regarding the the leg pain experienced by R2. accurate documentation to h investigation of the actual arred on 3/14/17 when R2	F514		ommittee will	
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE			



3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 577-6661

STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY:

ManorCare Pike Creek

DATE SURVEY COMPLETED: June 14, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
8	The State Report Incorporates by references and also cites the findings specified in the Federal Report. An unannounced complaint investigation survey was conducted at this facility June 6, 2017 through June 14, 2017. The facility census the first day of the survey was 177. The survey sample totaled six residents. In addition, one sub-sampled resident for observation.		*
3201	Regulations for skilled and intermediate care facilities		
3201.1	Scope		
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer Cross refer to the CMS 2567-L survey completed June 14, 2017; F0157, F0225, F0309, F0441, and F514.		

Provider's Signature